Arizona Medical Board

9545 East Doubletree Ranch Road • Scottsdale, Arizona 85258
Home Page: http://www.azmd.gov
Telephone (480) 551-2700 • Fax (480) 551-2704 • In-State Toll Free (877) 255-2212

FINAL MINUTES FOR REGULAR SESSION MEETING
Held at 9:30 a.m. on February 7, 2007 and 8:00 a.m. on February 8, 2007, 9535 E. Doubletree Ranch Road · Scottsdale, Arizona

Board Members

Robert P. Goldfarb, M.D., F.A.C.S., Chair
William R. Martin III, M.D., Vice Chair
Douglas D. Lee, M.D., Secretary
Patrick N. Connell, M.D.
Patricia Griffen
Becky Jordan
Ram R. Krishna, M.D.
Lorraine L. Mackstaller, M.D.
Sharon B. Megdal, Ph.D.
Dona Pardo, Ph.D., R.N.
Paul M. Petelin Sr., M.D.
Amy Schneider, M.D. F.A.C.O.G.

Executive Director's Report

Executive Director and Agency Office Reports

The Investigations Office completed 1811 investigations in the calendar year 2006 and for the month of January have been able to complete investigations with 135 days. Throughout the year 2006, the agency has been able to consistently stay below the180 day timeframe set for the agency by Auditor General's office to complete investigations.

The Licensing Office has seen an increase in the number of license applications received from the year 2005 by 237 more applications in the year 2006. Additionally, the timeframe to notify physicians of outstanding items necessary to complete their applications is 15 days.

The Information Services Office is in the first phase of the plan for the agency's new database and is setting ground work for creating the software. July 11, 2007 is the expected date to have the new database running.

The agency has also been able to concentrate on tasks within the community such as working with stakeholders to improve public health and working with the Governor's Office to help implement electronic medical records for physicians.

Pending Legislation – Involving the Board or Healthcare

The following Bills were brought to the Board's attention for informational purposes. The Board asked pertinent questions for clarification pertaining to the Bills below.

HB 2115- Non Disciplinary CME.
HB 2139- Definition for private practice for those exempt from having a DHS license.
HB 2357- Terminally ill patient assistance for control of suffering.
HB 2438- Requires the Arizona State Board of Pharmacy to establish a controlled substances prescription monitoring program.
HB 2572- Allows a qualified patient to make a written request for medication to end the patient's life.
HB 2578- Restricts health care businesses on disclosing an individual's identifiable health information to asite outside the U.S. unless consent is given by the individual.
HB 2581- Picture ID on licenses issued by a State agency.
HB 1015- Requires certain health care professionals in a health care institution to cooperate with police for investigation of intoxicated patients.
SB 1032- Requires the statutory elements of proof for medical malpractice cases related to certain emergency circumstances to be established by clear and convincing evidence.
SB 1100- Allows nurse practitioners to perform work as independent medical reviewers.
SB1248- AHCCCS shall maintain public records in computerized form regarding psychiatric medications administered to children.
SB 1249- Medication disclosure when prescribing psychotropic medications.
SB 1294- Establishes the Board of Surgical Assistants which is to be administered by the Arizona Medical Board.

Chair's Report

Robert P. Goldfarb, M.D. recognized Becky Jordan for her years of service on the Arizona Medical Board from July 1998 to February 2007 and presented her with a plaque.

Dr. Goldfarb also congratulated Timothy Miller, J.D., Executive Director for eliminating the Board's backlog of cases and thanked Christine Cassetta, Board Legal Counsel and Dean Brekke, Assistant Attorney General for their diligent work in protecting the citizens of Arizona.

Dr. Goldfarb also welcomed the Board's newest Member, Amy J. Schneider, M.D. from Tucson Arizona.

Litigator Report

Dean Brekke, Assistant Attorney General updated the Board regarding the Superior Court Decision re: Kenneth Fisher, M.D. and Shahid Malik, M.D. Mr. Brekke said there was a different judge on each case and one judge was concerned with the due process in the case of Dr. Fisher and the other judge was not concerned with due process in the case of Dr. Malik, although each case was handled identically. Mr. Brekke said, since the time of these cases, the Board now gives the physician to opportunity to respond to the Outside Medical Consultant's (OMCs) report before the case goes to the Staff Investigational Review Committee (SIRC).

Patrick N. Connell, M.D. noted Dr. Fisher had been before the Board many times and the physician was fully aware of the process and so due process should not be an issue. Timothy Miller, J.D., Executive Director said a new form has since been created that will show the physician waived the right to argue with the OMC and this should prevent due process issues in the future.

Consideration of Future Agenda Schedule and Case Load

Timothy Miller, J.D., Executive Director said Staff is encountering difficulties in scheduling physicians for Board meetings as there is a five to six month wait many times before there is room to schedule a case on the agenda. Robert P. Goldfarb, M.D. suggested the Board either conduct three day meetings or have a 1 day meeting every other month, or schedule the meetings to run for an extended length of time.

The Board agreed to hold a one day Board Meeting in May of 2007 and determine if other meetings needed to be held following that meeting. Robert P. Goldfarb, M.D. instructed Mr. Miller to take a consensus after the meeting to determine what day would work best for the Board Members.

Election of Board Officers

MOTION: Sharon B. Megdal, Ph.D. moved to elect by consensus those on the ballot for the Election of Board Officers.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

Dr. Megdal also noted this ballot form should be used in future elections. Timothy Miller, J.D., Executive Director announced the results of the 2007 Election of Board Officers: William R. Martin, III, M.D. Chair, Douglas D. Lee, M.D., Vice Chair and Dona Pardo, Ph.D., R.N., Secretary.

Dr. Martin thanked Robert P. Goldfarb, M.D. for his service during the year 2006 as Chairman of the Arizona Medical Board and commended his hard work on both behalf of the Board and the citizens of Arizona.

Draft Recommendations on Physician Assistant Supervision

William R. Martin, III, M.D. commended the Arizona Medical Board Physician Assistant Supervision Subcommittee Members for their work. The Subcommittee Members included: Robert P. Goldfarb, M.D., Ram R. Krishna, M.D., Patrick N. Connell, M.D., Becky Jordan and Paul M. Petelin, Sr., M.D. The Board Members agreed to the recommendations as presented by the Subcommittee.

Regulation of Surgical Assistants – Pending Legislation

Language has been drafted for a Bill that would prevent Surgical Assistants from practicing without a license. Christine Cassetta, Board Legal Counsel noted it is the practice in the community to currently use Surgical Assistants, but this may be a problem because of how Arizona statutes are written. Ms. Cassetta said the tasks performed by Surgical Assistants could be considered the practice of medicine; however, Surgical Assistants are not under a regulating body. The problem for physicians is that physicians may not associate with unlicensed practitioners of medicine.

Approval of Minutes

MOTION: Douglas D. Lee, M.D. moved to approve the November 30, 2006 Summary Action Meeting Minutes, Including Executive Session and the December 6-7, 2006 Regular Session Meeting Minutes, Including Executive Session.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

REVIEW OF ED DISMISSALS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0190A	R.L.	MARK J. SYMS, M.D.	30210	Uphold ED Dismissal.
2	MD-06-0388A	R.M.	MICHAEL A. EPSTEIN, M.D.	9945	Uphold ED Dismissal.

Paul M. Petelin, Sr., M.D. recused himself from this case. William R. Martin, III, M.D. abstained from voting on this case.

RM was present and spoke during the call to the public. RM said Dr. Epstein inappropriately treated her pain by failing to appropriately diagnose her with Trigeminal Neuralgia. EM also was present during the call to the public and spoke on behalf of his wife, RM. EM said Dr. Epstein explained his wife's pain away by concluding the pain was due to stress and said she simply needed anti-depressants. EM said Dr. Epstein failed to provide an adequate assessment of RM.

Mark Nanney, M.D., Chief Medical Consultant summarized the case for the Board. The Outside Medical Consultant (OMC) found Dr. Epstein's care to be within standard. The only issue the OMC had with the case was that Dr. Epstein failed to provide pain management for the patient on her first visit; however, he provided pain management on her second visit. A second OMC also reviewed the case came to the same conclusion. Robert P. Goldfarb, M.D. noted this patient had an unusual presentation for Trigeminal Neuralgia and Dr. Epstein appropriately attempted to rule out other possible diagnoses first. Dr. Goldfarb noted, although Dr. Epstein's bedside manner may not have been excellent, that was not a violation of the Medical Practice Act.

MOTION: Patricia R.J. Griffen moved to uphold the ED Dismissal.
SECONDED: Sharon B. Megdal, Ph.D.
VOTE: 10-yay, 0-nay, 1-abstain, 1-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-06-0482A	L.E.	VOLKER K. SONNTAG, M.D.	10422	Uphold ED Dismissal.

Robert P. Goldfarb, M.D. and Paul M. Petelin, Sr., M.D. recused themselves from this case.

LE was present and spoke during the call to public. LE asked the Board to reconsider the Executive Director's Dismissal as Dr. Sonntag waited three days before examining LE's post-surgery complaints.

William R. Martin, III, M.D. said he disagreed with both Outside Medical Consultants (OMCs) who reviewed the case as it seemed Dr. Sonntag missed LE's neck hematoma and early intervention would have prevented LE patient from having a year sequelae. However, Dr. Martin noted LE had an unusual presentation and Dr. Martin was not certain he could prove Dr. Sonntag should not have been missed the diagnosis.

MOTION: Lorraine Mackstaller, M.D. moved to reject the ED Dismissal and reschedule the case to be heard as an Advisory Letter.
SECONDED: Ram R. Krishna, M.D.

Patrick N. Connell, M.D. said it would be hard to support an Advisory Letter because both OMCs said Dr. Sonntag did not deviate from the standard of care.
VOTE: 3-yay, 7-nay, 0-abstain, 2-recuse, 0-absent
MOTION FAILED.

MOTION: Patrick N. Connell, M.D. moved to uphold the ED Dismissal.
SECONDED: Douglas D. Lee, M.D.
VOTE: 9-yay, 1-nay, 0-abstain, 2-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-06-0019A	BANNER GOOD SAMARITAN	LISA L. FULLER, M.D.	33576	Uphold ED Dismissal.

Lisa Fuller, M.D. was present with counsel, Mr. Gill Venable. Mr. Venable summarized the case and asked the Board to uphold the Executive Director's Dismissal.

Stephen Nelson, M.D. from Banner Good Samaritan was present and spoke in favor of the ED Dismissal. However, Dr. Nelson asked the Board to submit legislation to address independent practitioners who perform abortions in their offices unregulated. Dr. Nelson said the emergency room where he works sees several patients following complications from abortions performed by individual practitioners.

William R. Martin, III, M.D. asked Board Staff if cervical blocks, as used in abortions, would fall under the Office Based Surgery Guidelines and therefore under the jurisdiction of the Arizona Medical Board. Timothy Miller, J.D., Executive Director explained that abortions would not be covered under the Office Based Surgery Rules because facilities that conduct more than two abortions per year are licensed by the Arizona Department of Health Services. Robert P. Goldfarb, M.D. asked Staff to look into the issue further to see if the Board had any jurisdiction in the area of independent practitioners performing abortions in their offices.

MOTION: Sharon B. Megdal, Ph.D. moved to uphold the ED dismissal
SECONDED: Amy J. Schneider, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-06-0546A	M.M.	STEVEN D. KNOPE, M.D.	20845	Uphold ED Dismissal.
6.	MD-06-0297A	H.A.	RAY F. RHODES, M.D.	15171	Uphold ED Dismissal.
7.	MD-06-0657A	D.O.	KATHLEEN M. DUERKSEN, M.D.	21767	Uphold ED Dismissal.

Dr. Duerksen was present without counsel and spoke during the call to the public. He said he has taken the complaint seriously and feels he treated the patient appropriately and did not deviate from standard of care.

Robert P. Goldfarb, M.D. and Lorraine Mackstaller, M.D. recused themselves from this case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
8.	MD-06-0722A	L.M.	CRAIG G. GROSS, M.D.	25493	Uphold ED Dismissal.
9.	MD-06-0411A	D. L.	JEROMY S. BRINK, M.D.	31491	Uphold ED Dismissal.

Paul M. Petelin, Sr., M.D. recused himself from this case.

DL was present and spoke during the call to the public. This case had previously been voted on by the Board to uphold the ED Dismissal, However, the Board allowed DL to speak after the fact since she was not available to speak prior to the Board's vote on this matter. DL said Dr. Brink negligently prescribed a drug to her husband that he was highly allergic to and as a result her husband suffered a severe reaction. MH was also present and spoke during the call to the public on behalf of the patient. MH said the family was not aware the patient was prescribed a drug he was allergic to until she discovered the medication in his itemized bill after his death.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-06-0644A	R.L.	KENNETH B. GOSSLER, M.D.	23966	Uphold ED Dismissal.

RL was present and spoke during the call to the public and asked the Board to reconsider the Executive Director's dismissal. RL said he realized the allegations of the case were not a violation of the Medical Practice Act. However, RL said the Board should consider the ethical issues of the case.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-06-0266A	V.W.	KARL J. HEKIMIAN, M.D.	24591	Uphold ED Dismissal.
12.	MD-06-0391A	S.D.	MICHELE C. DE VITO, M.D.	24464	Uphold ED Dismissal.

SD was present and spoke during the call to the public. SD said Dr. De Vito ignored her complaints of pain and caused her unnecessary emotional and financial hardship as a result of her treatment.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
13.	MD-06-0242A	N.R.	JEFFREY B. LOOMER, M.D.	20557	Uphold ED Dismissal.

MOTION: William R. Martin, III, M.D. moved to uphold the ED Dismissal for cases 1 and 5-13.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

ADVISORY LETTERS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0182A	AMB	MEENAKSHI BELLAPRAVALU, M.D.	14728	Advisory Letter for failure to correlate bilateral ankle x-rays resulting in delay in treatment and surgery.
2.	MD-06-0130A	R.B.	WALTER E. KOPPENBRINK, M.D.	11324	Advisory Letter for using aspirin in a patient with GI bleed.
3.	MD-06-0399A	AMB	DONNA L. DEMING, M.D.	14573	Advisory Letter for failure to appropriately monitor an inmate with an acute abdominal pain.
4.	MD-06-0361A	K.Y.	MICHAEL J. MC CAULEY, M.D.	13247	Advisory Letter for failure to adequately assist a patient in titration of opioids in converting from Oxycodone to Morphine.
5.	MD-06-0419A	K.C.	JOSEPH G. RIZZA, M.D.	30111	Advisory Letter for inadequate management of a patient with a post-tonsillectomy bleed.

Ms. Kari Zangerle was present as counsel on behalf of Dr. Rizza. Ms. Zangerle spoke during the call to the public stating she said she had not had opportunity to submit pertinent materials to the Board as the Board's notice in the case was initially sent to a wrong address.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-06-0467A	J.D.	STEVEN STEINBERG, M.D.	20302	Invite the physician for a Formal Interview.

Paul M. Petelin, Sr., M.D. noted Dr. Steinberg's response indicated he was not aware of his failure in this case. Dr. Petelin said he saw a quality of care issue based on Dr. Steinberg's unavailability in this case.

MOTION: Paul M. Petelin, Sr., M.D. moved to invite the physician for a Formal Interview.
SECONDED: William R. Martin, III, M.D.
VOTE: 11-yay, 1-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-06-0341A	N.C.	JEFFREY I. WEISEL, M.D.	28553	Advisory Letter for failure to diagnose an acute spinal fracture.
8.	MD-06-0648A	D.W.	ARMANDO GONZALEZ, M.D.	24499	Advisory Letter for failure to properly follow up on an abnormal CT scan.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-06-0493A	J.W.	JAY S. NEMIRO, M.D.	12781	Invite the physician for Formal Interview.

Dona Pardo, Ph.D., R.N. suggested the Board issue non-disciplinary CME for documentation as Dr. Nemiro had a prior Board history for inadequate medical records. Amy J. Schneider, M.D. said the ZIFT procedure Dr. Nemiro used in this case seemed to be an inappropriate procedure.

MOTION: Amy J. Schneider, M.D. moved to reject the Advisory Letter and invite the physician for Formal Interview.
SECONDED: Dona Pardo, Ph.D., R.N.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
10.	MD-06-0014A	V.C.	ROBERT A. CAMPBELL, M.D.	32900	Continue the investigation and invite the physician for a Formal Interview.

Robert Campbell, M.D. was present without counsel and spoke during the call to the public. Dr. Campbell said most of the communication regarding this case was with the patient and not with the family as the patient was cognitive regarding his medical issues. Dr. Campbell said he did not delay in operating on the patient, but did allow a 72 hours period before surgery in order to push the medical therapy to the fullest extent before operating.

Paul M. Petelin, Sr., M.D. noted the Dr. Campbell's operative report was dictated one month after the patient's surgery and three weeks after the patient expired. Dr. Petelin asked Staff to notice Dr. Campbell for a violation of A.R.S. §32-1401(27)(e)- Failing or refusing to maintain adequate records on a patient, A.R.S. §32-1401(27)(t)- Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution and A.R.S. §32-1401(27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.

MOTION: Paul M. Petelin, Sr., M.D. moved to continue the investigation and invite the physician for a Formal Interview.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

Paul M. Petelin, Sr., M.D. noted the SIRC report stated the patient had an intestinal obstruction and that was incorrect. Dona Pardo, Ph.D., R.N. noted the two Medical Consultants in this case were in disagreement. However, Dr. Petelin noted both Medical Consultants found a deviation from the standard of care and a third Medical Consultant was not needed to review the case.

MOTION: William R. Martin, III, M.D. moved to issue Advisory Letters for items 1-5, 7, and 8.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

OTHER BUSINESS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0551A	AMB	GARRY W. POHORETSKY, M.D.	19736	Consent Agreement for a Letter of Reprimand for felonies, habitual intemperance and for failure to report his criminal charges to the Board within 10 days and one year Probation to undergo biological fluid testing.
2.	MD-06-0307A	AMB	KENNETH N. MCCORMICK, M.D.	17948	Consent Agreement for a Letter of Reprimand for misdiagnosing squamous cell carcinoma.
3.	MD-05-0031A	AMB	MARCIA A. MASTRIN, M.D.	31029	Consent Agreement for a Decree of Censure for improper treatment of an opioid addiction, improper prescription of Buprenorphine in an unapproved form and for inadequate medical records.

Marcia Mastrin, M.D. was present with counsel Ms. Ashley Adams. Ms. Adams spoke during the call to the public. Dr. Mastrin was informed by her employer that she was appropriately prescribing the pellet method of Buprenorphine. Dr. Mastrin now knows the pellet method of Buprenorphine is not legal, but at the time she believed and was told it was legal. None of her patients have had problems as a result of her treatment.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
4.	MD-06-0235A	DHS	JAMES L. SAMESHIMA, M.D.	24707	Consent Agreement for a Letter of Reprimand for failure to verify appropriate administration of medications and for failure to appropriately monitor medications for side effects.
5.	MD-05-0495A	AMB	RONALD L. CHRIST, M.D.	6644	Consent Agreement for a Letter of Reprimand for failure to arrange for a diagnostic endoscopic retrograde cholangiopancreatography.
6.	MD-05-0510A	A.A.	PAUL D. KAESTNER, M.D.	17448	Reject the Consent Agreement and invite the Physician

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
					for a Formal Interview.

Sharon B. Megdal, Ph.D. said she had concern in this case because it involved multiple patients in addition to multiple boundary violations.

MOTION: Sharon B. Megdal, Ph.D. moved to reject the Consent Agreement and invite the physician for a Formal Interview.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-05-1202D	AMB	NOEL A. YANESSA, M.D.	5412	Consent Agreement for a Letter of Reprimand for failure to detect an obvious significant pathology of the cervical, thoracic and lumbar spine on an MRI.
8.	MD-05-0515A	J.F.	CHUCK S. MANGUBAT, M.D.	24330	Consent Agreement for a Letter of Reprimand for failure to follow up on and inform the patient of x-ray results, for making a false statement in the medical record and for failing to maintain adequate patient records.

Mike Fleming was present on behalf of his father JF who was the patient in the case. Mr. Fleming said JF died due to a missed diagnosis by Dr. Mangubat. Mr. Fleming said not only did he misdiagnose his father, but he inappropriately diagnosed JF with alcoholism causing unnecessary emotional pain to both JF and his family during the end of JF's life.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
9.	MD-06-0408A	AMB	LAURENCE M. SUSINI, M.D.	17611	Consent Agreement for a Letter of Reprimand for failing to appreciate the degree of angulation and for failure to consider a closed reduction.
10.	MD-05-0648A MD-05-1034A	L.T. C.C.	DEVENDRA SONI, M.D.	27826	Consent Agreement for a Letter of Reprimand for failure to recognize, diagnose and treat SIRS in a timely manner and failure to frequently monitor MC until salicylate levels were potentially out of toxic range and one year Probation to complete Physician Assessment and Clinical Evaluation (PACE) record keeping course.

LT was present and spoke during the call to the public on behalf of her father. LT said Dr. Soni never saw her father in the hospital, when he should have presented, and subsequently wrote an erroneous medical record stating he had treated her father.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
11.	MD-06-0553A	AMB	ROBERT A. VAVRICK, M.D.	14500	Consent Agreement for a Letter of Reprimand for habitual intemperance and reporting to work under the influence of alcohol and a five year Probation with MAP terms.
12.	MD-06-0259A	M.S.	JOHN C. MORGAN, M.D.	25871	Consent Agreement for a Letter of Reprimand for failure to document the disposal of the Fentanyl patches in the medical records, for engaging in sexual conduct with a patient and for habitual intemperance and five year Probation with MAP terms.
13.	MD-04-0097A	AMB	DAVID D. DULANEY, M.D.	7924	Consent Agreement for Surrender of Active License.

Mr. Steve Myers and Mr. Cal Raup were present on behalf of Dr. Dulaney. Mr. Myers said Dr. Dulaney was currently in the Betty Ford Center for treatment. Dr. Dulaney requested that the Board rescind his agreement to Surrender his Arizona Medical license, but Staff said he did not have the opportunity to rescind the agreement. Mr. Myers requested the Board reconsider Dr. Dulaney's request to rescind the Surrender as Dr. Dulaney only signed the Surrender to prevent Summary Suspension of his license. Mr. Raup said Dr. Dulaney's Surrender of license was a serious decision that Dr. Dulaney did not have time to consider because he believe he had to sign the Agreement hastily.

Christine Cassetta, Board Legal Counsel informed the Board Dr. Dulaney requested the Surrender, refused to follow the Board's Order and subsequently submitted to a treatment facility of his own choosing and that facility does not have the Board's investigative materials of his case. Kathleen Muller, Physician Health Program Manager said Dr. Dulaney's counsel contacted her stating Dr. Dulaney did not wish to go to the evaluation Ordered by the Board and would prefer to Surrender his license. Ms. Muller said Dr. Dulaney subsequently returned the signed Surrender of License to the Board.

MOTION: William R. Martin, III, M.D. moved to accept the Consent Agreement for Surrender of Active License.
SECONDED: Douglas D. Lee, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr. and M.D. Amy Schneider, M.D. The following Board Member abstained: Patrick N. Connell, M.D. The following Board member was absent: Becky Jordan
VOTE: 10-yay, 0-nay, 1-abstain, 0-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
14.	MD-06-0240A	E.A.	DAVID D. DULANEY, M.D.	7924	Dismiss

Sharon B. Megdal, Ph.D. noted the SIRC report stated there was not a violation of the standard of care in this case and asked Christine Cassetta, Board Legal Counsel if the Board could still issue an Advisory Letter. Ms. Cassetta said a statutory violation must be sustained in order to issue an Advisory Letter.

Mark Nanney, M.D., Chief Medical Consultant noted Dr. Dulaney did not meet the patient until the date of surgery. Robert P. Goldfarb, M.D. said that was acceptable as long as Dr. Dulaney examined the patient the day of surgery as that was the community standard, although it may not be best practice. Ram R. Krishna, M.D. said he believed, if the surgery was elective, the physician should examine the patient on a day prior to surgery to give the patient time to decide if he/she still elected to have the surgery performed. Patrick N. Connell, M.D. noted Dr. Dulaney had the patient followed by an optometrist post operatively. Dr. Goldfarb opined that the surgeon has an obligation to be involved in the patient's post operative care.

MOTION: William R. Martin, III, M.D. moved to Dismiss the case.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 2-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
15.	MD-05-0866A	AMB	TIMOTHY J. GELETY, M.D.	21851	Deny Motion for Rehearing or Review.

Dean Brekke, Assistant Attorney General said the record supported the action taken by the Board in this case and the Board was justified in its previous decision. Ram R. Krishna, M.D. noted that nothing new had been submitted from the physician for the Board to review.

MOTION: Ram R. Krishna, M.D. moved to deny the Motion for Rehearing or Review.
SECONDED: Patricia R.J. Griffen
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
16.	MD-06-0489A	AMB	MARJORIE ALEXANDER, M.D.	N/A	Accept Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for habitual substance abuse.
17.	MD-05-0581A MD-05-0084A	B.B. AMB	THOMAS J. PETERS, M.D.	9582	Accept Finding of Fact, Conclusions of Law and Order for a Decree of Censure for mismanagement of a drug seeking patient, failure to appropriately supervise a medical assistant resulting in over-prescribing to patients and failure to maintain adequate medical records. Two year Probation to undergo CME in pain management and prescribing and shall undergo random chart review every six months.

BB was present and spoke on behalf of her daughter PB, now deceased. She said Dr. Peters performed an improper procedure on PB and inappropriately prescribed medications for PB.

MOTION: Douglas D. Lee, M.D. moved to accept Proposed Consent Agreements for items 1-5 and 7- 12 and with the referral of item 4 to the Arizona State Board of Nursing.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

MOTION: Patrick N. Connell, M.D. moved to accept Draft Finding of Fact, Conclusions of Law and Order for items 16 and 17.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

Wednesday, February 7, 2007

CALL TO ORDER
The meeting was called to order at 9:30 a.m.

ROLL CALL
The following Board Members were present: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr. and Amy Schneider, M.D.

CALL TO PUBLIC
Statements issued during the call to the public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0277A	C.P.	JOE T. HAYASHI, M.D.	12865	Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for failure to recognize the importance of adequately maintaining an adequate INR in face of multiple other risk factors for increase hypocoaguability and for failure to properly supervise a medical assistant. Two year Probation to include a PACE evaluation for general and internal medicine within 60 days and comply with any recommendations made by PACE. Board Staff shall conduct random chart reviews. The Probationary term shall not terminate upon completion of the PACE evaluation.

CP was present and spoke during the call to the public on behalf of her mother, the patient of Dr. Hayashi. CP said Dr. Hayashi's medical records were inadequate and he failed to properly manage her mother's care when 10 out of 13 laboratory reports showed her mother had subtherapeutic INRs. CP also noted Dr. Hayashi had a significant prior Board history.

Joe Hayashi, M.D. was present with counsel, Mr. Rick Delo.

Kelly Sems, M.D., Internal Medical Consultant summarized the case for the Board. Staff found Dr. Hayashi failed to properly monitor anticoagulation status for the patient, failed to maintain adequate medial records and failed to properly supervise his medical assistant.

Dr. Hayahsi said he did not feel it was necessary to micromanage the INRs as they were in the therapeutic range initially. Dr. Hayashi said his Medical Assistant (MA) did not notify him that the patient's last protime was low. Dr. Hayashi said he learned of this when he reviewed the chart a few days later on a Friday and he recommended the patient return to the office on Monday morning. However, the patient experienced a stroke over the weekend.

Lorraine Mackstaller, M.D. led the questioning. Dr. Mackstaller questioned Dr. Hayashi regarding the patient's subtherapeutic INRs and Dr. Hayashi said he thought they were just aberrations at first. Dr. Hayashi said he has since made changes in his office so that MAs cannot directly report labs or x-ray results to patients, but the results must be given instead to him. Robert P. Goldfarb, M.D. opined that Dr. Hayahsi should have had the patient present to his office on the Friday when he discovered the low protime. Dr. Goldfarb found Dr. Hayashi should have re-checked the patient's INR at that point instead of telling the patient to present on Monday.

William R. Martin, III, M.D. noted Dr. Hayashi had a prior Board history for a similar set of facts as in this case. Dr. Hayashi said this case was different because it demonstrated an administrative error in his office and was not due to medical negligence on his part.

Mr. Delo said there were not 10 subtherapeutic INRs in this case as even the Board's Medical Consultant found that many of the INR's for this patient were close to normal range. Dr. Hayashi refutes all of the allegations in this case.

Dr. Mackstaller said the patient had two mechanical valves, was in atrial fibrillation and because of such, it required the patient have an INR of 2.5 to 3.5. Dr. Mackstaller found Dr. Hayashi should have prescribed Aspirin for the patient when her INR fell to 1.6. Dr. Mackstaller also was concerned that Dr. Hayashi had the patient on hormones that increased the patient's risk for clotting. Dr. Mackstaller found actual harm in this case in that the patient suffered a cerebrovascular accident as a result of Dr. Hayashi's care.

MOTION: Lorraine Mackstaller, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401(27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public, A.R.S. §32-1401(27)(ii) - Lack of or inappropriate direction, collaboration or direct supervision of a medical assistant or a licensed, certified or registered health care provider employed by, supervised by or assigned to the physician and A.R.S. §32-1401 (27)(ll)- Conduct that the board determines is gross negligence, repeated negligence or negligence resulting in harm to or the death of a patient.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

MOTION: Lorraine Mackstaller, M.D. moved to Draft Finding of Fact, Conclusions of Law and Order for a Decree of Censure for failure to recognize the importance of adequately maintaing an adequate INR in the face of multiple other risk factors for increased hypocoagulation and for failure to adequately monitor office staff.
SECONDED: Ram R. Krishna, M.D.

Dr. Megdal suggested adding a Continuing Medical Education (CME) requirement to the Order along with a two year Probation for records review and without early termination of the Order. Dr. Goldfarb said he concerned about Dr. Hayashi's medical decision as evidenced in this case and noted Dr. Hayahsi testified he was currently monitoring 60 patients on Coumadin.

MOTION: Lorraine Mackstaller, M.D. moved to amend the motion to Draft Findings of Fact, Conclusions of Law and Order for a Decree of Censure for failure to recognize the importance of adequately maintaining an adequate INR in face of multiple other risk factors for increase hypocoaguability and for failure to properly supervise a medical assistant. Two year Probation to include a PACE evaluation for general and internal medicine within 60 days and comply with any recommendations made by PACE. Board Staff shall conduct random chart reviews. The Probationary term shall not terminate upon completion of the PACE evaluation.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr. and Amy J. Schneider, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
2.	MD-06-0055A	AMB	DIEGO G. CARDENAS, M.D.	19750	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for delay in diagnosis and treatment of a pregnant patient with bactiruria.

Diego Cardenas, M.D. was present with counsel, Dee Dee A. Holden.

Ingrid Haas, M.D., Medical Consultant summarized the case for the Board. Staff found Dr. Cardenas delayed in diagnosing and treating the patient's pyelonephritis and sepsis resulting in the death of the pregnant patient and her infant. Staff also found Dr. Cardenas's medical records were inadequate.

Patrick N. Connell, M.D. led the questioning. Dr. Connell noted if Dr. Cardenas would have accessed the patient's previous emergency room records, he would have seen the patient had multiple previous emergency department visits for a similar complaint as in this case. Dr. Connell noted the patient presented to Dr. Cardenas with a complaint of chills and that should have alerted him to do a work up for possible infection or sepsis. Dr. Connell noted a presentation of chills is was not consistent with the migraine diagnosis Dr. Cardenas made for the patient. Dr. Connell noted that a pregnant patient with a urinary tract infection poses special problems and if left untreated, asymptomatic bacteria may progress to symptomatic pyelonephritis. Dr. Cardenas said the patient's urinalysis results gave him no reason to believe she had a urinary tract infection. Dr. Connell said the clean catch specimen suggested there could be some external contamination and Dr. Cardenas had an obligation to attempt to resolve that. Dr. Connell also noted Dr. Cardenas should have addressed the patient's abnormal vital signs.

Lorraine Mackstaller, M.D. found Dr. Cardenas should have been alerted to a finding of hypothermia in this patient who was ill-appearing, tachycardic, had fevers, chills, nausea and whose urinalysis was abnormal. Amy Schneider, M.D. noted Dr. Cardenas should have ordered a catheterization to obtain a better urine sample despite his concern with the contamination on urinalysis. Douglas D. Lee, M.D. found Dr. Cardenas should have treated the patient with antibiotics prior to receiving the culture results. Dr. Cardenas said he believed the urinalysis at the time was not significant, but he does see its significance now in retrospect.

Ms. Holden said the patient's presentation to Dr. Cardenas was consistent with her migraine headaches. The patient was doing better by the time she left Dr. Cardenas's care and he was not responsible for the patient's death.

Dr. Connell said at the time Dr. Cardenas saw the patient there were many red flags such as chills, sweats, hypothermia, tachycardia, ill-appearing and a urinalysis suggesting infection. Dr. Connell noted there was no documentation that Dr. Cardenas adequately addressed the patient's issues. Dr. Connell noted actual harm in the delay in the diagnosis of urinary tract infection that ultimately led to the patient's and fetus's demise. Dr. Connell said the standard of care required Dr. Cardenas to address the abnormal urinalysis, address the patient's hypothermia, repeat the patient's vital signs, and document that he had addressed the patient's tachycardia.

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401(27)(e)- Failing or refusing to maintain adequate records on a patient and A.R.S. §32-1401(27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

MOTION: Patrick N. Connell, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for delay in diagnosis and treatment of a pregnant patient with bactiruria.
SECONDED: Douglas D. Lee, M.D.

Dr. Lee and Sharon B. Megdal, Ph.D. spoke against the motion stating Dr. Cardenas' actions did not rise to the level of disciplinary action and stated an Advisory Letter would be more appropriate in this case.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Paul M.

Petelin, Sr. and Amy J. Schneider, M.D. The following Board Members voted against the motion: Becky Jordan, Douglas D. Lee, M.D., Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D., R.N.
VOTE: 8-yay, 4-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
3.	MD-06-0274A	AMB	PATRICK J. DI FONZO, M.D.	29570	Advisory Letter for failure to discontinue a diuretic and for submitting false information to a hospital. The failure to discontinue a diuretic does not rise to the level of discipline.

Patrick Di Fonzo, M.D. was present with counsel, Mr. Tom Slutes.

Robert P. Goldfarb, M.D. said he knows Mr. Slutes, but it would not affect his ability to adjudicate the case.

Meagan Hinckley, Senior Medical Investigator summarized the unprofessional conduct issues for the Board. Dr. Di Fonzo admitted to altering a copy of a medical record that he submitted to the hospital for peer review. Roderic Huber, M.D., Medical Consultant summarized the quality of care issues for the Board. Dr. Di Fonzo deviated from the standard of care by failing to discontinuing the patient's diuretic when she was hypokalemic.

Robert P. Goldfarb, M.D. led the questioning. Dr. Di Fonzo admitted he did not stop the patient's diuretic and fell below the standard of care by not doing so. Dr. Di Fonzo also admitted he copied the medical records and altered a copy of the record to show he had discontinued the patient's diuretic and then submitted the false document to the hospital's peer review committee. Dr. DiFonzo said he had an enormous amount of personal and professional pressure at the time the circumstances in this case occurred and he was so overwhelmed, he felt he could not deal with another problem. Dr. Di Fonzo said, at the time, he believed that altering a copy of the record was the easy way to handle the issue. Dr. Di Fonzo said he immediately felt remorse for his dishonesty and admitted his alteration of the copied record before the Board's investigation began. Dr. Di Fonzo said he has now done things to reduce the stress in his personal and professional life and has completed 20 hours CME in Medical Ethics. Dr. Di Fonzo said he did not remove from the hospital or alter the original medical records at any time.

Dr. Goldfarb made a finding of unprofessional conduct in this case as Dr. Di Fonzo did not submit truthful information to the peer review committee.

MOTION: Robert P. Goldfarb, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(t)- Knowingly making any false or fraudulent statement, written or oral, in connection with the practice of medicine or if applying for privileges or renewing an application for privileges at a health care institution.
SECONDED: Patrick N. Connell, M.D.

Paul M. Petelin, Sr., M.D. spoke against the motion stating Dr. Di Fonzo's care was not a gross deviation from the standard of care and noted he was forthright with the Board in his testimony.

VOTE: 11-yay, 1-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

Dr. Goldfarb found Dr. Di Fonzo's failure to discontinue the diuretic for the patient did not rise to the level of disciplinary action. Dr. Goldfarb noted several mitigating factors in that Dr. Di Fonzo had no prior Board history and experienced a number of personal and medical issues that led to his false statement in this case. Dr. Goldfarb said, although the Board considers making false statements in the practice of medicine a severe issue, in this case, Dr. Di Fonzo's actions did not rise to the level of discipline.

MOTION: Robert P. Goldfarb, M.D. moved to issue an Advisory Letter for failure to discontinue a diuretic and for submitting false information to a hospital. The failure to discontinue a diuretic does not rise to the level of discipline.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr. and Amy J. Schneider, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

CALL TO THE PUBLIC

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
5.	MD-06-0293A	M.S.	RAMACHANDRA N. RAO, M.D.	25615	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inappropriate record keeping and failure to appropriately assess the patient.

MS was present and spoke during the call to the public. MS said Dr. Rao misdiagnosed his mother.

Ramachandran Rao, M.D. was present with counsel, Mr. Gordon M. Lewis.

Dr. Rao said he believed he provided appropriate care for the patient in this case. Dr. Rao said he was not told the patient was vomiting before and after leaving his office and the patient's pulse rate indicated she was not volume depleted at the time she left.

Kelly Sems, M.D., Internal Medical Consultant summarized the case for the Board. Staff found Dr. Rao failed to appropriately assess the patient and his medical records for the patient were inadequate.

Patrick N. Connell, M.D. led the questioning and noted Dr. Rao should have approached the patient's chief complaint of cough and shortness of breath with more concern based on her advanced age. Dr. Connell noted Dr. Rao's billing, coding and documentation were not congruent.

Lorraine Mackstaller, M.D. noted the patient was on multiple medications and was weak, tired, nauseated, constipated and had a known aortic valvular problem. Dr. Mackstaller noted these were all symptoms of hypokalemia that should have warranted Dr. Rao to obtaining lab work.

Mr. Lewis said Dr. Rao had an appropriate knowledge of the patient's history and did a reasonable assessment of the patient based on the information he was given during the visit.

Dr. Connell said he did not find evidence that Dr. Rao had a cognitive or knowledge deficit. However, Dr. Connell found Dr. Rao's medical record was inadequate and his medical decision making was too focused on one area. Dr. Connell said it was the standard of care for Dr. Rao to consider and document the patient's complete history of present illness and an appropriate review of systems for the presenting complaint and that appropriate evaluation occur when indicated. Dr. Connell found Dr. Rao did not take into account the complexity of the patient's complaints or her current medications and did not perform a review of systems. Dr. Connell found actual harm in that the patient's hypokalemia and hyponatremia likely progressed over the 48 hours after seeing Dr. Rao and the patient subsequently had an episode requiring hospitalization to bring her sodium level up

MOTION: Patrick N. Connell, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient and A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

MOTION: Patrick N. Connell, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for inappropriate record keeping and failure to appropriately assess the patient.
SECONDED: Patricia R.J. Griffen
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr. and Amy J. Schneider, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
6.	MD-05-0995A	C.M.	ANDREW A. KASSIR, M.D.	22649	Issue an Advisory Letter for delay in diagnosing intra-abdominal sepsis. This is a minor technical violation.

Andrew Kassir, M.D. was present with counsel, Mr. Neil C. Alden.

William Wolf, M.D., Medical Consultant summarized the case for the Board. Staff's review of the investigation showed Dr. Kassir deviated from the standard of care by failing to properly address the patient's post operative complication of bowel resection. Dr. Wolf noted there were several mitigating and aggravating factors in this case.

Paul M. Petelin, Sr., M.D. led the questioning. Dr. Kassir said his general practice was to refrain from performing surgery prior to leaving town. However, the patient's family preferred him to perform the surgery for the patient in this case. Dr. Petelin said Dr. Kassir should have immediately noticed a complication had occurred following surgery. Dr. Petelin noted the patient had to receive around 11 units of blood and a massive volume of fluids for resuscitation and this should have prompted Dr. Kassir to bring the patient immediately back to surgery for re-exploration. Dr. Petelin noted, regardless of what the fast scan showed, Dr. Kassir should have considered the patient to have a postoperative bleed until proved otherwise.

MOTION: Sharon B. Megdal, Ph.D. moved to go into Executive Session.
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

The Board went into Executive Session for legal advice at 4:38 p.m.
The Board returned to Open Session at 4:43 p.m.
No deliberations or decisions were made during Executive Session.

Mr. Alden asked the Board if they had the letter he submitted. The Board confirmed they had received the letter and took a moment to review it. Mr. Alden said multiple experts, specialists, subspecialist and nonsurgical specialist are in disagreement about what the best course was to pursue in this case. Therefore, Mr. Alden said this case was a matter of medical opinion and not fact on how it should have been handled.

Dr. Petelin noted there were mitigating factors in the case as Dr. Petelin found Dr. Kassir's testimony to the Board to have basis. Dr. Petelin also noted Dr. Kassir had no prior Board history. Dr. Petelin did not find unprofessional conduct in this case, but did opine Dr. Kassir needed to be more aggressive in treating post-operative complications and Dr. Petelin recommended non-disciplinary CME for such.

MOTION: Paul M. Petelin, Sr., M.D. moved to issue an Advisory Letter for delay in diagnosing intra-abdominal sepsis and 25 hours non-disciplinary CME in the diagnosis and management of postoperative complications. This is a minor technical violation.
SECONDED: Becky Jordan

William R. Martin, III, M.D. and Ram R. Krishna, M.D. spoke against the motion stating CME was not necessary in this case.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Douglas D. Lee, M.D., Lorraine Mackstaller, M.D. and Paul M. Petelin, Sr., M.D. The following Board Members voted against the motion: Patrick N. Connell, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., and Amy J. Schneider, M.D. The following Board Member abstained: Robert P. Goldfarb, M.D.
VOTE: 3-yay, 8-nay, 1-abstain, 0-recuse, 0-absent
MOTION FAILED .

MOTION: Ram R. Krishna, M.D. moved to issue an Issue an Advisory Letter for delay in diagnosing intra-abdominal sepsis. This is a minor technical violation.
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., and Amy J. Schneider, M.D. The following Board Members voted against the motion: Douglas D. Lee, M.D., Lorraine Mackstaller, M.D. and Paul M. Petelin, Sr., M.D.
VOTE: 9-yay, 3-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
7.	MD-05-0993A	AMB	FREDERIC D. LEARY, M.D.	11703	Advisory Letter for failing to timely recognize and address drug seeking behavior in a patient and inappropriate prescribing. This was a minor technical deviation.

Frederic Leary, M.D. was present with counsel, Ms. Sandra J. Rogers.

Carol Peairs, M.D., Medical Consultant summarized the case for the Board. Staff found Dr. Leary failed to timely recognize and address drug seeking behavior in a patient and inappropriately prescribed to the patient.

Douglas D. Lee, M.D. led the questioning. Dr. Lee noted Dr. Leary's medical records were inadequate and he overprescribed pain medicine for the patient. Dr. Leary conceded he did not meet the standard of care as he did not stay within safe levels of medication dosing to avoid real or potential complications. Ram R. Krishna, M.D. asked Dr. Leary if he had since improved his documentation. Dr. Leary said his records are improved and are now dictated and in electronic format. Lorraine Mackstaller, M.D. noted Dr. Leary was not aware the patient was on other medications from other physicians at the time he was prescribing for the patient.

Ms. Rogers said Dr. Leary understands there was a mistake in his prescription writing and although he does not use it as an excuse, his safety nets failed in this case as he is used to receiving calls from the pharmacy if he has overprescribed. Ms. Rogers said the patient was skillful at manipulation and Dr. Leary has since taken measures to better monitor his prescriptions for patients.

Dr. Lee noted Dr. Leary conceded to unprofessional conduct by failing to recognize the patient was prescribed an excessive amount of acetaminophen that was potentially toxic.

MOTION: Douglas D. Lee, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

Dr. Lee found it mitigating that the pharmacy did not catch the excessive medication prescribed and also found it mitigating that Dr. Leary was forthright with the Board in his testimony.

MOTION: Douglas D. Lee, M.D. moved to issue an Advisory Letter for failing to timely recognize and address drug seeking behavior in a patient and inappropriate prescribing. This was a minor technical deviation.
SECONDED: Becky Jordan
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr. and Amy J. Schneider, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

FORMAL HEARING MATTERS – CONSIDERATION OF ALJ RECOMMENDED DECISION

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC. #	RESOLUTION
1.	MD-06-0207A	N.R.	MARVIN L. GIBBS, M.D.	13736	Adopt ALJ's recommended Findings of Fact as presented. Adopt ALJ's recommended Conclusions of Law as presented, with the exception of #19. Adopt the ALJ's recommended Order for Suspension (time served), One year Probation during which time Board Staff shall conduct two random chart reviews.

Marvin Gibbs, M.D. was present with counsel, Mr. Daniel P. Jantsch.

Paul M. Petelin, Sr., M.D. said he knows Mr. Jantsch, but it would not affect his ability to adjudicate the case.

All the Board members confirmed they had received and reviewed the Administrative Law Judge's (ALJ's) recommended decision.

MOTION: Paul M. Petelin, Sr., M.D. moved to accept Mr. Jantsch's and the State's Motions for Good Cause.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

Anne Froedge, Assistant Attorney General summarized the case for the Board and asked the Board not to consider Exhibit "A" in Dr. Gibbs's response as it was not submitted as evidence during the Formal Hearing. Ms. Froedge also stated the State noted that the expert witnesses used by Dr. Gibbs did not specialize in the same area as Dr. Gibbs or perform similar procedures as Dr. Gibbs did in this case. The ALJ also adopted a standard of care that was not presented by the Board's Outside Medical Consultant, Taz Harmon, M.D. The ALJ also found Dr. Gibbs's records were inadequate and that he did not provide adequate instruction to the patient. The ALJ found Dr. Gibbs was dishonest in applying for hospital privileges and found Dr. Gibbs was motivated by financial gain. The State's position is that Dr. Gibbs is dangerous, his behavior is not going to be stopped and his license should be Revoked.

Mr. Jantsch acknowledged Dr. Gibbs's medical records were not adequate, but said he has since changed his practice. Mr. Jantsch said he disagreed with the standard of care as presented by the State and said the only problem Dr. Gibbs had in this case was inadequate documentation. Dr. Jantsch asked the Board to remove the Summary Suspension and reinstate Dr. Gibbs' license.

MOTION: Sharon B. Megdal, Ph.D. moved to go into Executive Session
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

The Board went into Executive Session for legal advice at 5:53 p.m.
The Board returned to Open Session at 5:59 p.m.
No deliberations or decisions were made during Executive Session.

The Board clarified it had granted the motions for good cause, but was not going to consider Exhibit A to Dr. Gibbs motion because it was evidence that was not submitted at the hearing.

MOTION: Sharon B. Megdal, Ph.D. moved to adopt the Findings of Fact as presented by the Administrative Law Judge.
SECONDED: Lorraine Mackstaller, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

MOTION: Sharon B. Megdal, Ph.D. moved to adopt the Conclusions of Law as presented by the Administration Law Judge with the exception of number 19.
SECONDED: Douglas D. Lee, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

MOTION: Sharon B. Megdal, Ph.D. moved to adopt the ALJ's recommended Order for Suspension (time served). Dr. Megdal also moved that, because of Dr. Gibbs's history with the Board, Dr. Gibbs should be placed on One year Probation during which time Board Staff shall conduct two random chart reviews.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr., M.D. and Amy J. Schneider, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

Controlled Substance Prescription Monitoring System

Members of the public were present to speak regarding current legislation for a Prescription Monitoring Program for Controlled Substances.

Stephen Borowski, M.D. from the Pain Management Association said physicians are in a hard position between providing appropriate pain management for patients while also avoiding inappropriate prescribing of drugs. Mr. Borowski said the Controlled Substance Prescription Monitoring System should eliminate concerns physicians face in this area. Mr. Borowski said the system allows physicians to review multiple prescriptions prescribed by multiple physicians for a particular patient. Mr. Borowski said the program is not open to mining for information by governmental agencies or other groups.

Hal Wand, Executive Director of the Arizona State Board of Pharmacy said there is not a fee to physicians to register in the Controlled Substance Monitoring System (System) as it will be paid for entirely by the Arizona State Board of Pharmacy. Currently the only penalty a physician would receive for not registering with the program would be reporting to the Arizona Medical Board and the physician would have no access to the System.

Robert P. Goldfarb, M.D. noted that anyone who registers with the System could access the information. Sharon B. Megdal, Ph.D. noted the database would include class 2-7 controlled substances although not all controlled substances are for the sole purpose of pain management. Douglas D. Lee, M.D. asked if physicians could potentially access information on individuals who were not their patients. Dean Wright, Policy Advisor for the Arizona State Board of Pharmacy said if physicians attempted to access information on patients other than their own, it would be considered a Class 6 Felony. Mr. Wright said he did not know how it would be discovered that an inappropriate inquiry was made, but that he would research the issue further and return to the Board with more information. Dr. Megdal said she was concerned with patient privacy with the proposed System. Mr. Wright clarified that for a physician to make a query he/she would need more than just the patient's name. The physician would need date of birth and other identifying information, but no decision has been made as to whether the other identifying information would include the patient's social security number or a portion of that number.

David Greenberg, M.D., Board Addictionologist said he realized the technical problems related to privacy are critical and should be worked out. However, Dr. Greenberg said he supports the System as there is not enough being done in the community to address controlled substance abuse.

The Board agreed to remain neutral on the topic in order to continue to obtain information regarding the Bill for the Controlled Substance Prescription Monitoring System.

Thursday, February 8, 2007

CALL TO ORDER
The meeting was called to order at 8:00 a.m.

ROLL CALL
The following Board Members were present: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr. and Amy Schneider, M.D.

CALL TO THE PUBLIC
Statements issued during the call to the public appear beneath the case referenced.

FORMAL INTERVIEWS

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
1.	MD-06-0018A	AMB	DONALD K. HOPEWELL, M.D.	33348	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for knowingly making a false statement to the Board on the license application.

Donald Hopewell, M.D. was present without counsel.

Robert P. Goldfarb, M.D. said certain hospitals in Tucson where members of his surgical group practice have contracted on certain cases with Sentient Medical Systems (SMS), but that would not affect his ability to adjudicate the case.

Marlene Young, Senior Medical Investigator summarized the case for the Board. Staff found Dr. Hopewell knowingly made a false statement to the Board on his license application.

Becky Jordan led the questioning. Dr. Hopewell said the Colorado Board told him they were going to deny his license, but they had not denied it at the time he completed the Arizona license application.

Ram R. Krishna, M.D. noted there was a letter from Colorado on May 17, 2004 stating the Colorado Board had denied his application for a license and Dr. Hopewell's application to the Arizona Medical Board was submitted on July 13, 2004, where Dr. Hopewell was not forthright that his application been denied in any other state. Dr. Hopewell said although he received the May 17, 2004 letter from the Colorado Board, they told him, over the phone, that his license was not yet denied and he could choose to go through an appeal period.

Dr. Hopewell conceded that the best approach would have been to have been straightforward with the Arizona Medical Board. Dr. Goldfarb noted there were further discrepancies in the timeline Dr. Hopewell submitted in his written response to the Board. Amy Schneider, M.D. asked Dr. Hopewell if he now considered his Colorado license denied. Dr. Hopewell said he did consider it denied at this point and has since reported

the denial on other license applications. Dr. Hopewell said it was not his intent to answer the Arizona application question incorrectly, but answered according to what he believed at the time.

Becky Jordan said she believed Dr. Hopewell felt that because his application was under appeal, it had not yet been denied. Ms. Jordan said the Colorado Administrative Law Judge dismissed Colorado Medical Board's denial of license on the grounds that the facts dealt with the company Dr. Hopewell worked for, SMS, and not problems with him. Ms. Young stated Dr. Hopewell was the president and Medical Director of SMS.

MOTION: Sharon B. Megdal, Ph.D. moved to issue an Advisory Letter for a technical violation on a license application.

The motion was not seconded and therefore failed.

MOTION: Ram R. Krishna, M.D. moved to find moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401(27)(jj) - Knowingly making a false or misleading statement to the board or on a form required by the board or in a written correspondence, including attachments, with the board.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

MOTION: Ram R. Krishna, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for knowingly making a false statement to the Board on the license application.
SECONDED: Paul M. Petelin, Sr., M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr. and Amy Schneider, M.D. The following Board Member voted against the motion: Becky Jordan
VOTE: 11-yay, 1-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

Douglas D. Lee, M.D. noted the Board seemed to have a number of cases similar to this case and wondered if there could be a clearer application process. Suzann Grabe, Licensing Office Manager said that with the new application implemented in Fall of 2006 clarification exists as there have been additional questions added on the application. Paul M. Petelin, Sr., M.D. asked Ms. Grabe to provide the Board with a copy of the new application.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
2.	MD-06-0396A	AMB	RENZO M. CATALDO, M.D.	29080	Advisory Letter for inadvertently reversing the postal and distal leads in the generator. This is a minor technical violation.

Renzo Cataldo, M.D. was present with counsel, Mr. Andrew Plattner.

Roderic Huber, M.D., Medical Consultant summarized the case for the Board. Staff found Dr. Cataldo inadvertently reversed the postal and distal leads in a pacemaker and then implanted the improperly assembled pacemaker in the patient.

Dr. Cataldo said the patient did not tell him he was not feeling well initially, but asked for reimbursement for having to have the shock pins readjusted within the pacemaker. The patient ultimately had a good outcome and was not exposed to any danger as a result of the coil switch.

Lorraine Mackstaller, M.D. led the questioning. Dr. Mackstaller noted the patient sustained inappropriate shocks from the pacemaker and asked Dr. Cataldo specific questions about the workings of the pacemaker. Robert P. Goldfarb, M.D. noted the deviation was that he installed the shocking coils in the header incorrectly. Douglas D. Lee, M.D. noted Dr. Cataldo did not deny the pacemaker leads were placed incorrectly.

Mr. Plattner said that Dr. Cataldo contributed to improving the quality of life for the patient and the patient was not in danger from the shocks the pacemaker delivered. Mr. Plattner said Dr. Cataldo has since changed his practice so that he only uses devices where this type of error can not occur.

Dr. Mackstaller found this was a minor technical error and noted the procedure improved the patient's life overall.

MOTION: Lorraine Mackstaller, M.D. moved to Dismiss the case.
SECONDED: Paul M. Petelin, Sr., M.D.

Sharon B. Megdal, Ph.D. spoke in favor for an Advisory Letter to create a record. Dr. Goldfarb agreed it was a technical violation that warranted an Advisory Letter. Dr. Lee and Dona Pardo, Ph.D., R.N. spoke against motion, stating that there was patient harm, as Dr. Cataldo agreed there was an error in placement of the leads. Paul M. Petelin, Sr., M.D. noted Dr. Cataldo did not have a chance to recognize the complication and treat it on his own because the patient moved out of state following the procedure.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patricia R.J. Griffen, Lorraine Mackstaller, M.D., Paul M. Petelin, Sr., M.D. and Amy J. Schneider, M.D. The following Board Members voted against the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D. and Dona Pardo, Ph.D, R.N.
VOTE: 4-yay, 8-nay, 0-abstain, 0-recuse, 0-absent
MOTION FAILED.

MOTION: Lorraine Mackstaller, M.D. moved to issue an Advisory Letter for inadvertently reversing the postal and distal leads in the generator. This is a minor technical violation.
SECONDED: Ram R. Krishna, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., and Amy J. Schneider, M.D. The following Board Member voted against the motion: Paul M. Petelin, Sr., M.D.
VOTE: 11-yay, 1-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
3.	MD-06-0292B	AMB	ERICK R. MARTINEZ, M.D.	20874	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to inform the patient that a requested and consented tubal ligation had not been performed during a C-section delivery.

Erick Martinez, M.D. was present with counsel, Mr. Gordon M. Lewis.

Ram R. Krishna, M.D. recused himself from the case.

Ingrid Haas, M.D., Medical Consultant summarized the case for the Board. The allegations in the case were that Dr. Martinez failed to perform tubal ligation for a patient and failed to advise the patient that the procedure had not been performed, resulting in an unwanted pregnancy.

Dona Pardo, Ph.D., R.N. led the questioning. Dr. Martinez said the consent form he was given in the hospital for the patient requested C-Section only. Dr. Martinez said the C-Section had to be performed emergently and he did not have time to reflect back and remember the patient had requested tubal ligation as well. Dr. Martinez said he has since changed his practice to ensure every consent form signed in his office for a procedure in the hospital is appropriately forwarded to the hospital. Dr. Pardo noted on the discharge form, the nurse discussed birth control with the patient and this should have prompted questions regarding tubal ligation. Dr. Pardo noted Dr. Martinez did not tell the patient he did not perform tubal ligation at the time of the patient's post-partum visit.

William R. Martin, III, M.D. noted Dr. Martinez's chart would have reflected he had a discussion with the patient pre-operatively regarding tubal ligation and, during the post-partum visit, review of his medical record would have reminded him he had not performed the procedure.

Amy J. Schneider, M.D. asked Dr. Martinez how he had changed his practice since this time. Dr. Martinez said he now processes consents in his office for elective surgery by immediately sending them to the hospital labor and delivery section so that they can be pulled in the case of an emergency.

Mr. Lewis said Dr. Martinez takes responsibility in this case and has taken steps to ensure a similar situation should not reoccur in the future.

Dr. Pardo said Dr. Martinez missed two opportunities to tell the patient the tubal ligation had not been done. Dr. Pardo stated the standard of care is to obtain proper consent and to perform the procedure indicated on the consent and inform the patient if the procedure is not carried out.

MOTION: Dona Pardo, Ph.D., R.N. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Sharon B. Megdal, Ph.D.
VOTE: 11-yay, 0-nay, 0-abstain, 1-recuse, 0-absent
MOTION PASSED.

Dr. Pardo noted there were mitigating factors in this case in that the nurse failed to discuss birth control when discharging the patient and also found it mitigating that Dr. Martinez has since changed his practice to prevent a similar situation from reoccurring.

MOTION: Dona Pardo, Ph.D., R.N. moved to issue an Advisory Letter for failing to inform the patient that the tubal ligation had not been performed. This was a technical violation.
SECONDED: Douglas D. Lee, M.D.

Dr. Martin and Dr. Schneider spoke against the motion stating this case warranted a Letter of Reprimand.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patricia R.J. Griffen, Douglas D. Lee, M.D. and Dona Pardo, Ph.D., R.N. The following Board Members voted against the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Becky Jordan, Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Paul M. Petelin, Sr., M.D. and Amy J. Schneider, M.D. The following Board Member was recused: Ram R. Krishna, M.D.
VOTE: 3-yay, 8-nay, 0-abstain, 1-recuse, 0-absent
MOTION FAILED.

MOTION: Amy J. Schneider, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to inform the patient that the tubal ligation had not been performed.
SECONDED: Patrick N. Connell, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr. and Amy J. Schneider, M.D.
The following Board member was recused: Ram R. Krishna, M.D.
VOTE: 11-yay, 0-nay, 0-abstain, 1-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
4.	MD-06-0622A	AMB	JAMES L. ROBROCK, M.D.	16209	Table the matter and bring it forward with the pending case.

James Robrock, M.D. was present with without counsel.

Erica Bouton, Senior Medical Investigator summarized the case for the Board. Dr. Robrock did not comply with his Board Order to complete psychiatric treatment.

Dr. Robrock informed the Board that because of financial burdens that he was forced to close his practice and has been unable pay for psychiatric treatment in order to comply with the Board Order.

Patrick N. Connell, M.D. led the questioning. Dr. Robrock confirmed it was violoation of the Medical Practice Act to not comply with the Board's Order. Dr. Robrock said he would like to practice medicine in the future, but cannot until financial and past behaviors are addressed.

Dr, Connell said he believed Dr. Robrock faced significant issues of depression and the Board's Order was an appropriate remedy for Dr. Robrock's situation. Dr. Connell also acknowledged Dr. Robrock was under financial burden.

MOTION: Patrick N. Connell, M.D. moved to go into Executive Session.
SECONDED: William R. Martin, III, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

The Board went into Executive Session for legal advice at 11:33 a.m.
The Board returned to Open Session at 11:37 a.m.
No deliberations or decisions were made during Executive Session.

Patrick N. Connell, M.D. noted Dr. Robrock had a pending investigation in addition to this case and that he was currently under an Interim Order for Practice Restriction regarding that case.

MOTION: Patrick N. Connell, M.D. moved to table the matter and bring it forward with the pending case.
SECONDED: Ram R. Krishna, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
5.	MD-06-0369A	AMB	THOMAS G. MOODY, M.D.	9470	Advisory Letter for performing an inappropriate preoperative measurement for intraocular lens replacement surgery. This was a minor technical error.

Thomas Moody, M.D. was present with counsel, Mr. Michael J. Ryan.

William Wolf, M.D., Medical Consultant summarized the case for the Board. Staff found Dr. Moody deviated from the standard of care by failing to assure that the patient had removed her contacts prior to the preoperative reading.

Dr. Moody asked that the record to reflect that he performed cataract surgery on one eye, not two as stated in the Board's materials. Dr. Moody expressed regret for not removing the patient's contacts prior to the preoperative testing. However, Dr. Moody said the patient's vision was improved to 20/20 following the surgery.

Ram R. Krishna, M.D. led the questioning. Dr. Moody said he has since developed a check list to assure contacts have been removed before the preoperative reading. Dr. Krishna noted this case was the first time Dr. Moody erred in this manner.

Mr. Ryan said the error in Dr. Moody's preoperative measurement did not cause the patient harm. Dr. Moody has developed a system that will prevent this from occurring again and Dr. Moody has no prior Board history.

Ram R. Krishna, M.D. said he did not question Dr. Moody's knowledge of this procedure and said he appreciated Dr. Moody's honesty in this case. Dr. Krishna found this case did not rise to the level of a disciplinary action; however he found an error was made.

MOTION: Ram R. Krishna, M.D. moved to issue an Issue an Advisory Letter for performing an inappropriate preoperative measurement for intraocular lens replacement surgery. This was a minor technical error.
SECONDED: Patrick N. Connell, M.D.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr. and Amy J. Schneider, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
6.	MD-05-0622A	AMB	MICHAEL S. BISCOE, M.D.	20915	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to recognize and treat meningococcemia in a timely manner, failure to repeat physical examinations during the time the patient was in the emergency department and for inadequate medical records.

Michael Biscoe, M.D. was present without counsel.

Patrick N. Connell, M.D. and William R. Martin, III, M.D. recused themselves from this case.

Kelly Sems, M.D., Internal Medical Consultant summarized the case for the Board. Dr. Sems stated the Dr. Biscoe fell below the standard of care by failing to diagnosis the patient's meningococcemia rash and poorly documenting what he had observed, resulting in the patient's death.

Dr. Biscoe admitted he did not recognize the patient's rash and did not have sufficient training in pediatrics. Dr. Biscoe said he made efforts to obtain outside consultations, but was unable to obtain one. Dr. Biscoe said he did not administer antibiotics initially as he was taught he must first identify the virus. Dr. Biscoe said he has since changed his practice as a result of this case and no longer works in emergency room settings.

Robert P. Goldfarb, M.D. led the questioning and noted Dr. Biscoe's medical records did not reflect the progressive changes that occurred with the patient within the patient's nine hour hospital stay. Dr. Goldfarb noted the medical records did not show the patient was adequately treated.

Robert P. Goldfarb, M.D. found Dr. Biscoe deviated from the standard of care by not frequently evaluating the patient and by delaying diagnosis and treatment of Meningococcemia that contributed to the patient's death. Dr. Goldfarb also noted Dr. Biscoe's medical records did not adequately reflect the patient's progress.

MOTION: Robert P. Goldfarb, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public and A.R.S. §32-1401 (27)(e)- Failing or refusing to maintain adequate records on a patient.
SECONDED: Ram R. Krishna, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 2-recuse, 0-absent
MOTION PASSED.

MOTION: Robert P. Goldfarb, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failure to recognize and treat meningococcemia in a timely manner, failure to repeat physical examinations during the time the patient was in the emergency department and for inadequate medical records.
SECONDED: Sharon B. Megdal, Ph.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr. and Amy Schneider, M.D. The following Board Members were recused: Patrick N. Connell, M.D. and William R. Martin, III, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 2-recuse, 0-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
7.	MD-06-0079A	E.A.	MICHAEL E. GRANBERRY, M.D.	28676	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to take a culture and failing to personally follow up on a post operative complication.

Michael Granberry, M.D. was present with counsel, Michael Wolver.

Robert P. Goldfarb, M.D. acknowledged that a late response was received from Dr. Granberry and there was a Motion for Good Cause pending asking the Board to accept the materials.

MOTION: Paul M. Petelin, Sr., M.D. moved to accept the Motion for Good Cause.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

William Wolf, M.D., Medical Consultant summarized the case for the Board. Dr. Wolf stated the Dr. Granberry deviated from the standard of care by failing to obtain bacteria cultures for a patient following post operative complications of laser surgery and by delegating the patient's post operative care to an optometrist who did not have the ability to adequately treat the patient's post operative complication.

Dr. Granberry stated antibiotics were administered for the patient every hour and that he was readily available for the patient's post operative care.

William R. Martin, III, M.D. led the questioning. Dr. Martin noted Dr. Granberry met with the patient one time pre-operatively and post-operatively, but did not rule out infection by performing a culture. Dr. Granberry said he does not see patients post-operatively and that is the community standard for ophthalmologists.

Paul M. Petelin, Sr., M.D. said the standard of care required Dr. Granberry to watch the patient more closely post-operatively and stated Dr. Granberry should have seen the patient during postoperatively when the patient's flap became infected. Dr. Granberry said he refers his patients to an optometrist to perform postoperative visits.

Dr. Granberry said he has since changed his practice to refer patients out upon any signs of infection.

Mr. Wolver said that the standard of care does not require Dr. Granberry to follow up directly with patients post-operatively.

Dr. Martin said the standard of care in a postoperative patient with a complication is to consider the complication to be an infection until proven otherwise. Dr. Martin noted the proper way to rule out infection is through a culture. Dr. Martin said it was not clear if Dr. Granberry was available for the patient's post-operative care.

MOTION: William R. Martin, III, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401(27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Patrick N. Connell, M.D.
VOTE: 12-yay, 0-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

Patrick N. Connell, M.D. noted it was Dr. Granberry's testimony that he refers the majority of his cases for post-operative follow up to an optometrist.

MOTION Patrick N. Connell, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for failing to take a culture and failing to personally follow up on a post operative complication.
SECONDED: William R. Martin, III, M.D.

Lorraine Mackstaller, M.D. noted referring post-operative patients to an optometrist is the standard in the community, whether it's best practice or not. Sharon B. Megdal, Ph.D. said this case was different because the patient had a complication and should have been seen by Dr. Granberry.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., William R. Martin, III, M.D., Sharon B. Megdal, Ph.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr. and Amy Schneider, M.D. The following Board Member voted against the motion: Lorraine Mackstaller, M.D.
VOTE: 11-yay, 1-nay, 0-abstain, 0-recuse, 0-absent
MOTION PASSED.

Ms. Cassetta noted for the record that the Board was the final arbiter of the standard of care and that a particular practice in the community is not necessarily equivalent to the standard of care.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
8.	MD-04-1183A	AMB	JOHN M. RITLAND, M.D.	17268	Advisory Letter for inadequate medical records, specifically on patients R.L. and T.W.P. The violation does not rise to the level of discipline.

John Ritland, M.D. was present without counsel.

Douglas D. Lee, M.D. recused himself from this case.

Ingrid Haas, M.D., Medical Consultant summarized the case for the Board. The IMC reviewed several medical records for various patients in this case and found deviations. Staff felt Dr. Ritland could benefit from undergoing Continuing Medical Education (CME) for high risk pregnancy.

Dr. Ritland said the cases reviewed by the Board did not reflect his usual care as the records selected by Staff were for his high risk patients with complications. Dr. Ritland said he provided appropriate care in the cases the Board reviewed.

Paul M. Petelin, Sr., M.D. led the questioning and asked Dr. Ritland to respond about certain allegations regarding his care of patients, K.McM, TWP, MM, AB and RL.

Paul M. Petelin, Sr., M.D. noted that for patient K.McM, Staff found his treatment was below the standard of care by initiating uterine stimulants on a patient whose labor was progressing appropriately. For patient TWP, Staff found Dr. Ritland deviated from the standard of care by failing to record on the history and physical that the patient presented with elevated blood pressures and proteinuria. For patient MM Staff found Dr. Ritalnd failed to document appropriate prenatal monitoring or twin gestation that might be harmful to the mother or infants and inappropriately performed an elective C-section for twins at 37 and ½ weeks. For patient AB, Staff noted Dr. Ritland deviated from the standard of care by inducing the patient without proper indication. Dr. Ritland said he believed AB met the criteria of induction by being more than one hour from the hospital however, he said he did not know AB was in fact located close to another hospital. For patient RL, Staff found Dr. Ritland negligently

performed a C-section at 35.5 weeks gestation with placenta praevia even though bleeding and contractions had stopped, and his care resulted in a premature infant delivered.

Dr. Petelin said he found Dr. Ritland's answers to be explanatory and therefore could not sustain unprofessional conduct in this case.

Amy J. Schneider, M.D. found Dr. Ritland did not maintain adequate documentation for patients RL and TWP. Dr. Schneider said that for TWP, Dr. Ritland's history and physical lacked significant information for a patient presenting with elevated blood pressures and proteinuria and patient RL's medical records contained no documentation of a history and physical.

MOTION: Amy J. Schneider, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401(27)(e)- Failing or refusing to maintain adequate records on a patient.
SECONDED: Patrick N. Connell, M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent
MOTION PASSED.

MOTION: Paul M. Petelin, Sr., M.D. moved to issue an Advisory Letter for inadequate medical records, specifically on patients R.L. and T.W. The violation does not rise to the level of discipline.
SECONDED: Patrick N. Connell, M.D.

Amy J. Schneider, M.D. felt this should rise to a higher level of discipline. Lorraine Mackstaller, M.D. said she did not believe the case rose to a disciplinary level as Dr. Ritland performed 400 deliveries; Staff reviewed 17 charts and found only eight that had deviations.

ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Robert P. Goldfarb, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr. and Amy Schneider, M.D. The following Board Member was recused: Douglas D. Lee, M.D. The following Board Member was absent: Sharon B. Megdal, Ph.D.
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent
MOTION PASSED.

NO.	CASE NO.	COMPLAINANT v PHYSICIAN		LIC.#	RESOLUTION
9.	MD-06-0318A	AMB	LARRY P. PUTNAM, M.D.	9233	Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for habitual intemperance, inappropriate prescribing and for failing to maintain adequate records on a patient. Five year Probation with MAP terms including a treating psychiatrist (He shall receive credit for the time he was under the interim order for MAP).

Larry Putnam, M.D. was present with counsel, Mr. Dan Cavett.

Robert P. Goldfarb, M.D. recused himself from the case.

Lorraine Brown Senior Compliance Officer summarized the unprofessional conduct issues for the Board. Dr. Putnam signed an Interim Consent Agreement for Practice Restriction he successfully completed a chemical dependence treatment program. Dr. Putnam underwent a neuropsychological evaluation in October of 2006 that revealed he had cognitive improvement from a previous evaluation. Kelly Sems, M.D., Internal Medical Consultant summarized the quality of care issues and stated Dr. Putnam prescribing repeatedly to a patient without establishing an appropriate physician/patient relationship.

Dr. Putnam acknowledged his abuse of Ambien and said he entered treatment in April 2006. Dr. Putnam said he has remained in compliance with the Board's Monitored Aftercare Program.

Ram R. Krishna, M.D. led the questioning. Dr. Putnam confirmed he inappropriately prescribed medications to a patient. Paul M. Petelin, Sr., M.D. questioned Dr. Putnam's cognitive ability to perform medicine and Dr. Putnam stated he felt he was fully capable to return to practice. Dr. Putnam told the Board that Ambien is the only drug he has abused and it is not available in the Anesthesia setting where he would be practicing.

Mr. Cavett said Dr. Putnam's October 2006 neuropsychological report clarified that his cognitive deficits were no longer an issue. Mr. Cavett told the Board that during Dr. Putnam's recent military service overseas Ambien was readily provided to him to assist in the situations and work he was put in. Mr. Cavett said Dr. Putnam was a victim of his circumstances.

Ram R. Krishna, M.D. commended Dr. Putnam for his military service. However, Dr. Krishna stated Dr. Putnam fell below the standard of care by prescribing medication to a colleague, without documentation, posing potential harm to the patient. Additionally, Dr. Krishna noted Dr. Putnam diverted some of the Ambien he prescribed to himself.

MOTION: Ram R. Krishna, M.D. moved for a finding of Unprofessional Conduct in violation of A.R.S. §32-1401(27)(e)- Failing or refusing to maintain adequate records on a patient, A.R.S. §32-1401(27)(f)- Habitual intemperance in the use of alcohol or habitual substance abuse, A.R.S. §32-1401(27)(j)- Prescribing, dispensing or administering any controlled substance or prescription-only drug for other than accepted therapeutic purposes and A.R.S. §32-1401 (27)(q)- Any conduct or practice that is or might be harmful or dangerous to the health of the patient or the public.
SECONDED: Paul M. Petelin, Sr., M.D.
VOTE: 10-yay, 0-nay, 0-abstain, 1-recuse, 1-absent
MOTION PASSED.

The Board discussed what type of Practice Restriction would be appropriate for Dr. Putnam. Lorraine Mackstaller, M.D. suggested restricting his work schedule to 20 hours per week. Ram R. Krishna, M.D. suggested restricting Dr. Putnam to work in a group setting and Paul M. Petelin, Sr., M.D. felt a restriction of 40 hours per week was appropriate. Douglas D. Lee, M.D. said he did not feel Dr. Putnam's work hours should be restricted and if there were a restriction, it should be in effect for only the first six months of his Order. Ms. Cassetta noted if it was the Board's intention that Dr. Putnam return to work immediately it should consider dealing only with the Letter of Reprimand and MAP Probation in its Order and address the issue of the conditions necessary for Dr. Putnam to return to work in a separate motion because if the return to work is included in its disciplinary Order, Dr. Putnam could not return to work until months from now when the Board's Order was final. The Board agreed to separate the matter and have Dr. Putnam's return to work handled in an Interim Consent Agreement negotiated between Ms. Cassetta and Mr. Cavett.

MOTION: Ram R. Krishna, M.D. moved to Draft Findings of Fact, Conclusions of Law and Order for a Letter of Reprimand for habitual intemperance, inappropriate prescribing and for failing to maintain adequate records on a patient. Five year Probation with MAP terms including a treating psychiatrist (He shall receive credit for the time he was under the interim order for MAP).
SECONDED: Patrick N. Connell, M.D.
ROLL CALL VOTE: Roll call vote was taken and the following Board Members voted in favor of the motion: Patrick N. Connell, M.D., Patricia R.J. Griffen, Becky Jordan, Ram R. Krishna, M.D., Douglas D. Lee, M.D., Lorraine Mackstaller, M.D., William R. Martin, III, M.D., Dona Pardo, Ph.D, R.N., Paul M. Petelin, Sr. and M.D. Amy J. Schneider, M.D. The following Board Member was recused: Robert P. Goldfarb, M.D. The following Board Member was absent: Sharon B. Megdal, Ph.D.
VOTE: 10-yay, -nay, 0-abstain, 1-recuse, 1-absent
MOTION PASSED.

Following the Board's vote, Ms. Cassetta asked the Board for clarification regarding the consent agreement it asked her to negotiate with Dr. Putnam in order to return to work. The Board clarified the restriction as follows: Dr. Putnam's practice is restricted in that he shall not work more than forty hours per week for six months from the date of the Interim Consent Agreement and his practice shall be supervised by a physician in his group practice who, at the conclusion of the six month period, shall submit a report to Board Staff regarding his recommendation that Respondent resume an unrestricted practice. If the report recommends an unrestricted practice, the Executive Director shall vacate the Interim Practice Restriction. The April 24, 2006 Interim Consent Agreement for Practice Restriction terminates upon the effective date of the Amended Interim Consent Agreement for Practice Restriction.

The meeting adjourned at 5:38 p.m.

Timothy C. Miller, J.D., Executive Director